Public Health – Seattle & King County Referral Form

This Public Health Nurse Referral form can be completed online. The PDF file will not allow you to save a completed version of the referral form. Print the completed referral and FAX to Public Health at (206) 296-4679.

Required fields must be completed and are indicated in the directions below. Non-required fields can be left blank or marked 'unknown' if information is not known. Below are instructions for completion of the form, in the order the fields appear on the form:

H/R #:	**PH staff only:** Enter the client's Public Health health record number.
Name (Required field)	Enter the client's Last Name, First Name, and Middle Initial.
Maiden Name or AKA	Maiden name or other name client may be known under.
Address (Required field City (Required field) & Zip (Required field))	Enter the street address, name of the city and zip code of the client's home (or address where client is currently staying if not at home address).
DOB (Required field)	Enter the client's date of birth.
Social Security Number	Enter the client's social security number
Marital Status	Enter the Marital Status of the client in space provided. If unknown or unsure, write "unknown."
Gender: (Required field)	Mark the appropriate gender for the client.
Home Phone, Cell and/or Secondary phone	Space is provided for primary and secondary phone numbers for client. A checkbox is provided to indicate if it is permitted to leave a message at the phone number(s) listed.
Provider One #	Write in the client's Medicaid Provider One number in space provided, if applicable
Family Size	Write in total number of members in this family.
Income	Write in the gross monthly income for the family, if known.
Emergency Contact and Phone #	Write in the name and telephone number of the emergency contact person for the client in space provided, if known.
Race (Required field)	Mark the race the client identifies for self **(all that apply)**. If unknown or unsure, mark as "unknown."
Ethnicity (Required field)	Mark (one) ethnicity of the client. If unknown or unsure, mark as "unknown."
Interpreter Needed* Y/N *(Required field)	Mark whether interpreter is needed and indicate language.
Referred by: Name & Phone number of referent and Date of referral	Enter the name of the person making the referral. Indicate the agency and phone number (include area code) where the referent can be reached. Enter the date referral is being made.

Agency Type ***(Required field)***	Mark a box indicating type of agency making the referral.
Family aware of referral, PHN to contact referent before/after contact	Mark whether client is aware the referral is being made and whether the nurse should contact the referent before or after the client visit.
Referral Type ***(Required field)***	Indicate the main reason for the referral by checking the appropriate box and completing the requested information. • **Prenatal**. For **Nurse Family Partnership** referrals, check the NFP box in the Notes section near the bottom of the form. • **Postpartum/Newborn** Include mother and infant's health care provider name(s) and phone number(s), if known. • **Pediatric** referral for infants older than two months of age or children up to 18 years of age. • **SIDS/Bereavement:** enter the **Date of Death** in space provided.
Risk Factors	Mark **all factors that apply** to the client and family being referred for services. Space is provided to add information about breastfeeding concerns or delivery complications for postpartum clients.
Additional information	Document additional information about the client's health condition or risk factors to be addressed. Examples: health or social history, medical conditions, hospitalization, feeding/lactation problems or services being requested. For **Nurse Family Partnership** referrals, check the NFP box in this section.
Names of additional family members on referral	Write in the full **name**, **birth date**, **sex**, and **race** for additional family members of the client that you would like added to this referral for services. If referring a infant or child, include mother's name here. **PH staff only**: when taking referrals, include the **Health Record number** for PH clients with existing health records.
For Internal Use Only	**PH staff only**: This section only for use by public health nurses doing Hospital rounds to identify clients needing home visiting services.
Label Area	**PH staff only**: Apply client label once referred client is registered in the PH system.